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The Pulse of CMS

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Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

CMS Welcomes New Administrator

As reported in the last edition of *The Pulse of CMS*, the Senate confirmed Mark B. McClellan, M.D., Ph.D., as the new Administrator of the Centers for Medicare & Medicaid Services (CMS). Dr. McClellan comes to CMS from the Food and Drug Administration (FDA), where he served as the Commissioner since November 2002. As Commissioner of the FDA, he was responsible for the oversight of the safety of pharmaceuticals, biological products and medical devices, as well as the safety of food and cosmetics.

Both a physician and an economist, Dr. McClellan has an extensive background in medicine, economics and academia. Prior to joining FDA, Dr. McClellan was Associate Professor of Economics at Stanford University, Associate Professor of Medicine at Stanford Medical School, a practicing internist, and Director of the Program on Health Outcomes Research at Stanford University. He was also a Research Associate of the National Bureau of Economic Research and a Visiting Scholar at the American Enterprise Institute. Additionally, he was a Member of the National Cancer Policy Board of the National Academy of Sciences, Associate Editor of the Journal of Health Economics, and co-Principal Investigator of the Health and Retirement Study (HRS), a longitudinal study of the health and economic well being of older Americans. From 1998-99, he was Deputy Assistant Secretary of the Treasury for Economic Policy, where he supervised economic analysis and policy development on a wide range of domestic policy issues.

During 2001 and 2002, Dr. McClellan served in the White House as a member of the President's Council of Economic Advisers, where he advised on domestic economic issues. He also served during this time as a senior policy director for health care and related economic issues for the White House. *Fortune* magazine named Dr. McClellan as one of their "People to Watch" in February 2003.

At his hearing before the Senate Finance Committee, McClellan stated, "I believe CMS is one of the nation's most important public health agencies…with an absolutely critical public health role to play not only in helping millions of Americans get access to high-quality health care, but also in making our health care system fundamentally better. I am honored to have the opportunity to join the CMS workforce, particularly at a time when the challenges and rewards of working at CMS have never been greater."

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CMS Hosts Partners at National Drug Conference

The Centers for Medicare & Medicaid Services hosted a two-day information session entitled "The Medicare-Approved Drug Discount Card: The First Step," in early April in Washington, D.C., to provide information about the new 18-month program and enlist help in reaching out to beneficiaries nationwide.

The discount drug program authorized by the Medicare Modernization Act (MMA) will make Medicare-approved discount cards available to Medicare beneficiaries without prescription drug coverage. The Medicare-approved cards will offer beneficiaries savings of at least 10 to 17 percent for brand name drugs and far larger savings for generic drugs compared with the average prices paid by all Americans.

CMS Administrator Mark B. McClellan, M.D., Ph.D., noted that this program provided the most far-reaching changes to Medicare since its inception and urged attendees to partner with CMS to educate seniors and others who are eligible for the program to ensure that they have the information they need to make the best choices for themselves and their families.

Over 800 participants at the conference attended the plenary sessions that provided a broad overview of the drug discount program and perspectives on the program from the states, Congress and the prescription drug industry. Additional enrichment sessions offered attendees the opportunity to learn more about specific aspects of the program including the complaint process, the outreach and education strategy, counseling beneficiaries, the web-based tool for selecting a drug card and media training.

Click here for conference materials, presentations and web cast of the conference.

Modification of HIPAA Contingency Plans

Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Accountability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA-compliant formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004. The rules will apply to claims received on or after July 1, 2004.

CMS has also instructed its Medicare carriers and intermediaries to make available free, low/cost software that will enable submission of HIPAA compliant claims electronically. Contact your carrier or intermediary in order to obtain this software at their special EDI number. Providers can review the detailed article in Medlearn Matters Article # 2981 on our website.

A list of these numbers by State is available at:
Part A:
http://www.cms.hhs.gov/providers/edi/anum/asp.
Part B:
http://www.cms.hhs.gov/providers/edi/bnum/asp

Provider Outreach Staff:

David Hinson
Phone: (404) 562-7365

E-mail your questions and comments to us at: Atl_Provider Questions@cms.hhs.gov

Additional free subscriptions to The Pulse can be obtained by registering on our list-serv at: http://list.nih.gov

Select Browse, then enter: Atl_Pulse_Sub-L and complete the popup data form

Focus on MMA: Medicare Advantage

On December 8, 2003 President Bush signed into law the Medicare Modernization Act of 2003, commonly referred to as the MMA. Among the many provisions impacting the health care community in this landmark legislation is Title II – Implementation of the Medicare Advantage (MA) Program.

Medicare Advantage, New Name – Same Old Managed Care Program?
Not really. The Medicare Advantage (MA) program replaces the Medicare + Choice program and contains significant new features to provide a greater selection of health plan options to Medicare beneficiaries. Among these new features are:

- Establishing MA "Regional" plans or organizations
- Introducing competitive bidding
- Enhanced payments to MA organizations

Depending on the plan offerings in a given area, beneficiaries may have the choice of traditional fee-for-service Medicare, local coordinated health plans such as HMOs, provider-sponsored organizations (PSOs), preferred provider organizations (PPOs) serving regional and/or local areas, medical savings accounts (MSAs), and private fee-for-service (PFFS) plans. The legislation also provides for the possibility of "specialized" MA plans that offer a specialized set of services and may limit enrollment to beneficiaries with specialized needs, such as institutionalized or Medicaid eligible individuals or those with severe or disabling chronic conditions.

Beginning in 2006, MA plans will bid competitively against a benchmark, and bids from private plans and rates for traditional FFS Medicare will be averaged to create a benchmark for competitive bidding. CMS will be able to negotiate bid amounts with plans to determine the best price.

Already the legislation has resulted in increases in payments to existing MA health plans. The increases, effective March 1, 2004, average 10.6 percent across plans. The provision requires that the organizations use the funds to:

- Reduce beneficiary premiums or co-pays
- Enhance benefits
- Stabilize or expand the networks of doctors and other health care providers available to members
- Reserve the funds to offset either premium increases or reduced benefits in the future

So, what does that mean to health care providers?
Increased capitation payments to plans coupled with the new flexibility given to CMS to contract with a variety of types of plans appear almost certain to result in more managed care options available to more beneficiaries. In some areas of the country, CMS has already seen an increased interest in service area expansions from existing plans as they consider moving into counties with increased capitation payments. Providers also appear to be interested in pursuing a contract to provide "specialty care" services under the new legislation.

Expansions of existing plans into new geographic areas and new contracts with new MA plans will require additional providers and suppliers to serve those contracts, and potential opportunities for the provider community at large. The success of this new provision will depend, in part, on the outreach and education to Medicare beneficiaries and the sharing of information with the health care provider community.

Elimination of Grace Period for Billing Discontinued Codes

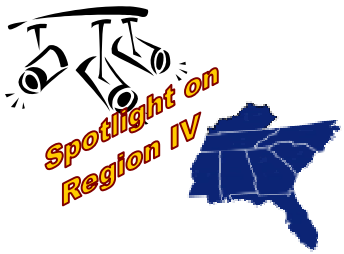
Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers and DMERCs will no longer be able to accept discontinued codes for dates of service after the date on which the code is discontinued. Adopt the new codes in your billing processes effective October 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of your claim.

Providers can view new, revised, and discontinued ICD-9-CM diagnosis codes at http://www.cms.hhs.gov/medlearn/icd9code.asp. CMS updates this site annually after the updated diagnosis codes are published in the Federal Register, which usually occurs by October 1 of each year.

To view the actual instruction issued by CMS to your Medicare carrier, please go to:

http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf

Click here to view the MedLearn Matters article on this issue.



"The Pulse" will highlight data and facts pertaining to the states in Region IV This quarter we feature North Carolina in the spotlight. Keep your eye out for more interesting facts from the other states in the region in upcoming issues!

Did you know…

NC spent $3,535 per capita on health care in 1998?

NC is the 32nd largest state in health spending in the nation?

NC ranks 26th in the nation for population 65 and over?

NC was ranked as the 4th fastest growing state in the U.S. during the 1990s?

NC ranks 31st in Medicare spending per enrollee?

Additional HIPAA Instructions Announced

Effective July 1, 2004, Medicare systems are enforcing additional HIPAA edit instructions related to X12N 837 Institutional Claims. The HIPAA Implementation Guide for the 837 transactions requires these changes. It is important for providers to become familiar with the changes. Failure to comply will result in claim rejects and accompanying payment delays. Providers need to be sure billing processes comply with the changes to continue correct and timely payments.

Once the inbound claim process was in order, CMS began to work on the coordination of benefits (COB) transaction. Many new issues have arisen since the trading partners treat these COB records, also known as crossover claims, as inbound claims. Medicare's business rules were different from other payers. The changes that will take effect in July fall into three primary categories:

- Medicare will now require certain data elements that are not needed for Medicare but required by HIPAA.
- Data previously allowed by Medicare, but not permitted by HIPAA, will result in claims rejections.
- Certain data that Medicare now edits only for syntax will be edited for content and will cause claim rejections if the data is not valid.

Providers and their submitters should carefully review the requirements in Medlearn Matters Article # 3031 to ensure that claims are not unnecessarily rejected effective July 6, 2004.

For all you need to know about the latest in HIPAA, please visit the CMS website!

Spinning the CMS "Wheel of Websites"

It's not always easy to locate the information you need on the CMS website. But there is help…the CMS Website Wheel. The Website Wheel is a webpage-locating tool designed to help find information on the CMS website by specific topic. When the arrow is pointed at a topic, the exact URL for that page shows through the window.

Website wheels are one of the most popular items given out at the CMS exhibit booth at conferences around the country. They are also one of the many free educational products that can be ordered directly online at the Medicare Learning Network (Medlearn) webpage at www.cms.hhs.gov/medlearn.

Visit the Medlearn Webpage for other educational resources such as web-based training courses; educational videos, CD-ROMs, and training guides; publications; and information about upcoming training events and video broadcasts.

HHS Announces Quality Improvement Initiative for Beneficiaries with Chronic Illnesses

CMS recently announced a new Medicare initiative to improve the quality of care for people living with multiple chronic illnesses by helping them manage their conditions and encouraging better coordinated care. Beneficiaries who agree to participate will receive help in managing their conditions, following their physicians' plan of care and ensuring that they know about, and can take advantage of, Medicare-covered benefits that will help to reduce their health risks.

Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures. For example, about 14 percent of Medicare beneficiaries have congestive heart failure but account for 43 percent of Medicare spending. About 18 percent of Medicare beneficiaries have diabetes, accounting for 32 percent of Medicare spending.

CMS is seeking innovative proposals from qualified organizations to run large-scale chronic care improvement projects to help beneficiaries with congestive heart failure, complex diabetes and chronic obstructive pulmonary disease. CMS will choose about 10 projects, which will run for a three-year period, from specific regions around the country. Each project will provide participating beneficiaries with information and support to help them better care for their conditions.

CMS published a notice in the April 23 Federal Register soliciting proposals from organizations to provide care support services for beneficiaries with multiple chronic conditions, including congestive heart failure, complex diabetes, and chronic obstructive pulmonary disease (COPD). Click here for more information.

CMS Participates in NRHA Annual Conference

The National Rural Health Association held its 27th Annual Conference from May 25-29, 2004 in San Diego, CA. This year's theme was "Working Together for Excellence and Access," and featured speakers and exhibitors from all facets of the health care sector serving rural populations. The CMS Regional Rural Health Coordinators from all ten Regional Offices attended the meeting and met with various rural health partners from their respective states over the course of the conference. CMS also sponsored an exhibit booth where regional office staff distributed information on the new Medicare legislation as well as provided a live demonstration of the prescription drug and other assistance programs website, where participants were able to use the database to search for the drug card program that best fit their needs. CMS is looking forward to participating in next year's annual conference, which will be held on May 17-21, 2005 in New Orleans.

Opportunities for Providers in New Programs Under MMA

Medicare demonstration projects are funded by Congress to develop and test innovative program ideas in the Medicare program. Many of these projects have helped shape many of the changes in the Medicare program. Numerous demonstration projects are included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). CMS is gearing up to implement these projects, which address coverage of certain prescription drugs, rural community hospitals, quality of care, chronic care improvement, and more.

The following is just a small sample of the MMA Demonstration Projects. Go to http://www.cms.hhs.gov/researchers/demos/MMAdemolist.asp for more information on these and other demonstration projects.

Section 409 -- Rural Hospice Demonstration Project: Requires the Secretary to conduct a demonstration project, lasting not longer than five years, providing hospice care in three facilities of 20 or fewer beds located in rural areas, in which Medicare beneficiaries are currently unable to receive hospice care for lack of an appropriate caregiver.

Section 649 -- Medicare Care Management Performance Demonstration: Requires the Secretary to conduct a three-year demonstration program where physicians will be paid to adopt and use health information technology and evidence-based outcome measures to promote continuity of care, stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes.

Section 651(b) -- Demonstration of Coverage of Chiropractic Services Under Medicare: Requires the Secretary to establish a two-year demonstration program at four sites to evaluate the feasibility and desirability of covering additional chiropractic services under Medicare, as specified in the legislation. The Secretary is required to evaluate whether beneficiaries who participate in the demonstrations use fewer Medicare covered services than those not participating, the cost of providing such chiropractic services under Medicare, quality of care and satisfaction of participating beneficiaries, and other appropriate factors.

Calendar of Events

July 30-31: Exhibit at the Louisiana & Mississippi Hospice Associations, New Orleans, LA

August 5-8: Exhibit at the American Association of Pharmacy Technicians, Wilmington, NC

August 19-21: Exhibit at the Alabama Hospice Association, Mobile, AL

September 24-30: Exhibit at the Alabama Nursing Home Association, Birmingham, AL

September 29-30: Exhibit at the Tennessee Hospital Association, Nashville, TN

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